STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155723	A. BUILDING 00 B. WING	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN 47715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 18, 19, 20, 21, 22, 25, 26, 2012 Facility number: 002280 Provider number: 155723 AIM number: N/A Survey team: Amy Wininger, RN-TC June 18, 19, 20, 21, 22, 25, 2012 Diane Hancock, RN Vickie Ellis, RN Barbara Fowler, RN Census bed type: SNF: 48 Residential: 37 Total: 85 Census payor type: Medicare: 28 Other: 57 Total: 85 Residential sample: 7 The deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on July 2, 2012 by Bev Faulkner, RN			

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F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on interview and record review, the facility failed to ensure residents were informed of their resident rights during their stay in the facility, for 3 of 4 residents interviewed regarding resident council, in that residents were not periodically informed of their resident rights. (Resident #87, Resident #169, Resident #8) and failed to ensure a notice of medicare non-coverage was provided to 1 of 3 residents who met the criteria for review of appeal rights. (Resident #8) Findings include: 1. Resident #87 was interviewed on 6/21/12 at 9:15 a.m. Resident #87 indicated resident rights have not been reviewed. Resident #87	F0156	F 156 Res #8, #87 and #169 were provided a copy of resident rights. **Completion Date 7-26-12** Res #8 was provided an explanation of Medicare non-coverage. **Completion Date 7-26-12** There were no other residents affected and through inservicing will ensure resident rights are provided periodically and non-coverage letters are sent . **Completion Date 7-26-12** Activity staff inserviced on requirement of resident rights to be provided. Business office manager inserviced on non-coverage criteria and cut letter requirements.	07/26/2012

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	indicated the facility did not have resident council meetings and usually the Activity Assistant would come to her room and ask her questions. Resident # 87's quarterly BIMS (Brief Interview for Mental Status) score completed on 5/7/12 was 15/15, indicating her long term and short term memory is intact. 2. Resident #169 was interviewed on 6/21/12 at 9:30 a.m. Resident # 169 indicated the facility did not have resident council meetings and no one had discussed her resident rights with her. Resident # 169's annual BIMS score for 3/16/12 indicated a 15/15, indicating her long and short term memory is intact. 3. Resident #8 was interviewed on 6/22/12 at 10:20 a.m. Resident # 8 indicated she had never attended a resident council meeting and did not know the facility had a resident council. Resident #8 indicated her resident rights have not been reviewed. Resident #8 indicated she did not know what her resident rights were. Resident #8's BIMS score was completed on 3/14/12 and indicated a score of 15/15, indicating her long and short term memories were intact. On interview with the A.D. (Activity		**Completion Date 7-26-12** **Activity Director will interview 3 skilled residents randomly/week to ensure they acknowledge receipt of resident rights.** **Executive Director will audit Medicare non-coverage log weekly to ensure compliance with requirement of notification.** **Monthly QA meeting will include the review of the log and cut letters as well as the interview audits x3 months and quarterly thereafter.**	

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	Director) on 6/21/12 at 10:15 a.m., she indicated that she did not usually meet with the residents on the Health Center unit. She indicated the Assistant Activity Director met with them and that the Assistant Activity Director had indicated she had reviewed the rights with the residents during the resident council meetings. Resident #87, Resident #169, Resident #8 indicated they had not attended a resident council meetings. The "Resident Move-in Guide," obtained from the ED (Executive Director) on 6/22/12 at 4:00 p.m., indicated the residents have the right to be fully informed of their rights. 4. In an interview on 06/22/12 at 8:15 a.m. with the B.O.M. (Business Office Manager), she indicated Resident #8 had exhausted her Medicare benefits. The B.O.M. further indicated, at that time, she didn't know she was supposed to provide a letter when Medicare benefits were exhausted. In an interview with the HFA (Health Facility Administrator) on 6/22/12 at 9:10 a.m.. she indicated Resident #8 should have received a notice of Medicare Non-coverage. The Form Instructions for the Notice			

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	of Medicare Non-Coverage provided by the HFA on 06/22/12 at 4:00 p.m.. indicated, "When to deliver...A Medicare provider...must give an advance, completed copy of the Notice of Medicare Non-coverage to beneficiaries...receiving skilled nursing,...not later than 2 days before the termination of services..." 3.1-4(a)			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview, and record review, the facility failed to ensure the physician was notified of problems with a colostomy appliance for 1 of 2 residents reviewed for	F0157	F 157 Resident #1's physician was notified of current condition of stoma site. **Completion Date 7-26-12**	07/26/2012

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	colostomy care in a sample of 2 residents who met the criteria for colostomy care. (Resident #1) Findings include: Hospice Nurse #2 and LPN #1 were observed on 06/18/12 at 2:52 p.m., providing colostomy care due to leakage to Resident #1. Resident #1 was observed at that time to be grimacing throughout the procedure and stated, "That is so tender!" At that time, the skin surrounding the stoma was observed to be bright red, raised, shiny, and excoriated. In an interview at that time, LPN #1 indicated Resident #1 was receiving Diflucan (an oral antifungal medication) for colostomy excoriation. LPN #1 stated, at that time, "It's horrible looking, but it did look like hamburger...when he goes [has a bowel movement] it just sits on that skin and then it leaks." The Hospice Nurse stated, at that time, "We are gonna come out Thursday (6/21/12) and assess for new appliance." LPN #1 was then observed to apply a new colostomy appliance to the excoriated skin surrounding the stoma. The clinical record of Resident #1 was reviewed on 6/20/12 at 10:44		There were no other residents affected by the alleged deficient practice and through corrective actions will ensure any changes in resident #1's colostomy will have immediate M.D notification. **Completion Date 7-26-12** Licensed nurses will be inserviced on notification requirements. **Completion Date 7-26-12** DHS/Designee will audit TAR daily x30 days and monthly thereafter to ensure that timely M.D notification is achieved if appliance change is more frequent than ordered. **Results of audits will be forwarded to QA committee for review of compliance and suggestions monthly x6 and quarterly thereafter.**	

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	a.m. The record indicated the diagnoses included, but were not limited to, CVA (a stroke) with left sided hemiparesis. The most recent quarterly MDS (Minimum Data Set Assessment), dated 06/07/12, indicated Resident #1 had an ostomy. A Physician's Progress Note, dated 06/07/12, indicated, "site at ostomy [arrow up] red...substancial [sic] redness around his ostomy...ostomy site candidiasis..." The Nursing Notes from 06/07/12 at 7:45 p.m. through 06/21/12 at 1:00 p.m. were reviewed and lacked any documentation that the attending physician had been notified the colostomy appliance was not functioning (leaking) due to the excoriated skin. A plan of care, dated 06/18/12, for hospice included, but was not limited to, interventions "observe for signs/symptoms of pain or discomfort, such as facial grimacing, c/o [complaint of] pain, moaning or restless movements and treat per order promptly, notify MD [medical doctor] and hospice if pain or discomfort is not alleviated by current medication treatment regimen..."			

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	A plan of care for skin condition, dated 06/11/12, for "irratiation [sic] at stoma site" with interventions that included, but were not limited to, assess/record changes in skin status, report pertinent changes in skin status to MD. A plan of care for ostomy, dated 03/23/12, included, but was not limited to interventions "observe ostomy site daily for redness/swelling...notify physician of any problems...." In an interview on 6/20/12 at 10:18 a.m., with Hospice Nurse #1 she indicated the new colostomy supplies "will be taken care of by the hospice wound care person on 06/21/12.". In an interview with LPN #1 on 06/22/12 at 9:50 a.m., she indicated the colostomy appliance had been changed daily "for a couple of weeks" and there had been no change to the type of colostomy appliance used for Resident #1. In an interview with the DoN (Director of Nursing) on 06/22/12 at 10:00 a.m., she indicated the physician should have been, but was not notified of the rash around the stoma interfering with the functioning of the colostomy			

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	appliance. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation, interview, and record review, the facility failed to ensure residents were aware of their right to review the most recent survey results and the location of the survey reports for 4 of 5 resident interviewed for knowledge of right to review and location of survey results (Resident #87, Resident #169, Resident #84, Resident #8) Findings include: 1. Resident #87 was interviewed on 6/21/12 at 9:15 a.m. Resident #87 indicated she did not know where the most recent survey results were kept. Resident #87 further indicated the facility does not have resident council meetings and usually the activity assistant will come to her room and asked her questions instead of having a meeting. Resident #87's quarterly BIMS (Brief Interview for Mental	F0167	F 167 Resident #8, #84, #87 and #169 have been informed of their right to review the survey results and the location of the survey results. **Completion Date 7-26-12** Since other residents have the potential to be affected they have been given the information of their right to access the survey results and where they are located also. **Completion Date 7-26-12** Activity Director and Admissions staff have been inserviced on the resident right to review survey results and through this inservicing will ensure that they are given this information upon admission as well as through monthly council meetings. **Completion Date 7-26-12** Activity director will randomly interview 3 skilled residents/week to ensure they have received their	07/26/2012

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	Status) score completed on 5/7/12 was 15/15, indicating her long term and short term memory is intact. 2. Resident #169 was interviewed on 6/21/12 at 9:30 a.m. Resident #169 indicated she did not know where the most recent survey results were kept and further indicated the facility did not have resident council meetings. Resident # 169's annual BIMS score for 3/16/12 indicated a 15/15, indicating her long and short term memory is intact. 3. Resident #84 was interviewed on 6/21/12 at 9:45 a.m. Resident #84 indicated he did not know where the most recent survey results were located and really did not know the most recent survey report was available for residents. Resident #84 indicated he had not attended a resident council meeting for at least 6 months. Resident #84's BIMS score completed on 3/26/12 indicated a 11/15 which indicated some long and short term memory deficit. 4. Resident # 8 was interviewed on 6/22/12 at 10:20 a.m. Resident # 8 indicated she was not aware where the most recent survey results were located. Resident # 8 indicated she had never attended a resident council		rights and information of survey results. **Results of interviews will be forwarded to QA committee monthly x3 months and quarterly thereafter for review.**	

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	meeting and did not know the facility had a resident council. Resident # 8 indicated she did not what her resident rights were. Resident #8's BIMS score was completed on 3/14/12 and indicated a score of 15/15, indicating her long and short term memories were intact. During an interview with the A.D. (Activity Director) on 6/21/12 at 10:15 a.m., she indicated the residents were informed where the most recent survey were located during their resident council meetings. Resident # 87, Resident #169, Resident #84, and Resident #8 were indicated to have attended a resident council meeting within the last 6 months but the residents verbally indicated they did not attend resident council meetings. The resident council minutes were reviewed on 6/20/12 at 1:45 p.m. The minutes lacked any documentation that survey results were reviewed during any resident council meetings. The minutes lacked any documentation related to the location of the survey book. The survey results were observed on			

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	155723	A. BUILDING 00 B. WING	06/26/2012

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	a table behind the front desk in the lobby on 06/22/12 at 1:30 p.m. In an interview, at that time, the E.D. [Executive Director] indicated the residents were able to access the survey results as the residents come behind the front desk for concerns and issues frequently. The "Resident Move-in Guide" for residents, obtained on 6/22/12 at 4:00 p.m. for the ED (Executive Director), indicated the residents have a right to examine the most recent survey and the facility's plan of correction. 3.1-3(b)(1)			

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F0226 SS=A	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure the policy and procedure for reporting an allegation of theft was followed (Resident #73) for 1 of 3 abuse investigations reviewed and failed to ensure that verbal abuse did not occur for 1 of 3 abuse investigations reviewed (Resident #121), in that, an allegation of verbal abuse was substantiated and an allegation of theft was not reported to the police. Findings include: 1. A Resident Concern Form, dated 02/12/12, was provided by the HFA (Health Facilities Administrator) on 06/21/12 at 1:00 p.m. The report indicated Resident #73 had reported "missing red cosmetic bag with billfold in it with [sic] patient states $300-$400 in billfold." The investigation indicated the money had not been located. The follow-up investigation lacked any indication the police had been notified of the report	F0226	Res #73 and #121 no longer reside at the facility.There were no other residents affected by the deficient practice and through training/education will ensure that missing money is reported to the local police and that abuse prevention measures are in place.Completion Date 7-26-12Administrator will be inserviced on Elder justice act and required notification.Completion Date 7-26-12All allegations of missing property and abuse will be forwarded to QA committee monthly for review of investigation and proper follow up.	07/26/2012

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	of missing money. In an interview with the HFA (Health Facilities Administrator) on 06/21/12 at 1:00 p.m., she indicated the police had not been notified in regards to the report of missing money. The Abuse and Neglect Procedural Guidelines provided by the HFA on 06/18/12 at 2:15 p.m., indicated, "...g. Reporting...v. The Elder Justice Act requires that if the event that caused the suspected abuse/neglect resulted in serious bodily injury, the Executive Director or designee is required to report the suspicion to the police department immediately, but not later than 2 hours. If the event does not result in bodily injury, it must be reported no later than 24 hours." 2. An Incident Report Form, dated 02/07/12, was provided by the HFA on 06/21/12 at 1:00 p.m. The report indicated an allegation of verbal abuse was made on 02/07/12 at 11:30 p.m., by Resident #121. The report further indicated, "Immediate Action taken: Investigation initiated, statements obtained during interviews CRCA [Certified Resident Care Assistant] admitted utilizing curse word unintentionally from stress while in the presence of resident. CRCA			

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	was placed on suspension immediately pending outcome of investigation. Additional witness was found and after completion of investigation it was determined that CRCA violated facility policy. CRCA was termed [terminated] from employment...". In an interview with the HFA on 06/21/12 at 1:00 p.m. she indicated the facility investigation concluded verbal abuse had occurred and the employee was terminated. The Abuse and Neglect Procedural Guidelines provided by the HFA on 06/18/12 at 2:15 p.m., was reviewed at that time. The facility adhered to the procedural guidelines for the screening, training, prevention, identification, protection, investigation, and reporting of abuse. 3.1-28(a)			

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F0241 SS=B	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and record review, the facility failed to provide meals in a dignified manner by yelling out the names of residents, when passing trays to identify who the tray belonged to in 3 of 14 residents observed dining in the health center dining room, and by vacuuming in the room of a resident during a meal in 1 of 2 residents observed dining in their room. (Residents #172, #53, #89, & #13) Findings include: 1. During the lunch meal observation on 6/21/12 at 12:28 p.m., MDS (Minimum Data Set Assessment) Coordinator #1 yelled out Resident # 172's last name three times until Resident # 172 raised her hand. MDS Coordinator #1 then delivered the tray to Resident #172. During that same meal CRCA (Certified Resident Care Associate) #2 was observed yelling out Resident #53's last name 3 times with no answer. She then returned the tray to the cart.	F0241	F 241 Res #172, #53, #89, and #13 suffered no ill effects from findings of the 2567L and through corrective action will ensure that dignity is maintained throughout the meal service. **Completion Date 7-26-12** All residents have the potential to be affected by the alleged deficient practice and will have the same dignified meal service provided through corrective actions. **Completion Date 7-26-12** In-service for all staff that assist with meal service to include table service process. In-service for housekeeping regarding appropriate activity during the dining process. **Completion Date 7-26-12** Executive Director/designee will monitor 2 random meals per day x2 weeks, 1 random meal per day x2 weeks, 2 random meals per week x 2 months, then 2 random meals per month thereafter. **Results of audits will be**	07/26/2012

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	MDS Coordinator #1 was then observed to yell out Resident #89's name. The resident's family member then stated "over here" and CRCA #2 delivered the tray to Resident #89. A book provided by the Administrator on 6/22/12 at 10:00 a.m., and titled Resident Move-in Guide with no reference date, indicated the facility would honor and assist with the resident's right to maintain "independent functioning, dignity, and well-being." 2. LPN #1 was observed to deliver Resident #13's lunch at 12:25 p.m., on 6/21/12, and then left the room. The housekeeper then entered the room, plugged in the vacuum cleaner, indicated she was going to vacuum the floor and proceeded to vacuum the floor while the resident was eating her lunch. The Administrator and Director of Nurses indicated, on 6/18/12 at 5:30 p.m., the housekeeper should not have vacuumed the floor while the resident was eating lunch. 3.1-3(t)		**reported to QA committee monthly x6 months and then quarterly.**	

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F0242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview, and record review, the facility failed to ensure resident choices were honored for having a shower for 1 of 2 residents who met the criteria for choices. (Resident #1) Findings include: The clinical record of Resident #1 was reviewed on 6/20/12 at 10:44 am. The record indicated the diagnoses included, but were not limited to, Cerebrovascular Accident (a stroke) with left sided hemiparesis. In a family interview on 06/19/12 at 8:54 a.m., the spouse of Resident #1 stated, "He wants to take a shower and it takes three people to shower him, so he has only had a bedbath for the last two months...They don't have a shower room...for people like [Resident #1's name]."	F0242	F 242 Resident #1 has his preferences documented and careplanned accordingly. **Completion Date 7-26-12** Staff that care for Res #1 have been inserviced on his preferences and plan of care. **Completion Date 7-26-12** There were no other residents affected and through inservicing and obtaining preferences will ensure those who want a shower receive it. **Completion Date 7-26-12** Systemic change is that bathing preference will be entered into resident profile on caretracker. **Completion Date 7-26-12** Nursing staff will be inserviced on resident profile procedure and preferences. **Completion Date 7-26-12** DHS/designee will monitor 3 residents bathing preferences per	07/26/2012

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	Resident #1 was observed on 06/19/12 at 9:00 a.m., to be lying in bed. In an interview, at that time, Resident #1 indicated he would like to take a shower. In an interview with CRCA (Certified Resident Care Associate) Preceptor on 06/20/12 at 10:56 a.m., she stated, "I gave [Resident #1] a partial bath this morning before breakfast." The CRCA Preceptor further indicated Resident #1 was not able to take a shower. In an interview with CRMA (Certified Resident Medication Associate) #1 on 06/21/12 at 11:29 a.m., she indicated Resident #1 received hospice services for bedbaths, but he was not able to take a shower because he leans in the chair. In an interview with MDS (Minimum Data Set Assessment) Coordinator #1 on 06/21/12 at 10:22 a.m., she stated "[Resident #1] does not get a shower related to his inability to stay properly positioned in the shower chair, if he desired a shower [Resident #1] could be brought up to the spa on the second floor. The MDS Coordinator #2 provided, at that time, a Bathing Detail report that indicated Resident #1 had not received a shower or full		day x2 weeks ,3 per week x2 months and 3 per month thereafter to ensure care is reflective of resident preference. **Results of audits will be provided to QA committee monthly for review x6 months and quarterly thereafter.**	

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	bath in the last 30 days. The most current care plan for Resident #1, revised on 03/30/12, identified a problem of self-care deficit "needs assistance or is dependent in ...bathing with interventions that included, but were not limited to, ...assist with personal hygiene as needed...provide only the amount of assistance/supervision that is needed with ADL's [Activities of Daily Living]..." The plan of care did not address any concerns with the resident not being able to take a shower. The most recent Resident First Conference Notes, dated 05/03/12, lacked any documentation of skin concerns, ostomy site concerns, or nursing issues. The meeting summary area lacked any documentation. In an interview with the DoN (Director of Nursing) on 06/22/12 at 10:00 a.m., she indicated the plan of care for ADL self-care deficit did not address the resident's wish to receive a shower. The most recent quarterly MDS, dated 06/07/12, indicated Resident #1 experienced moderate cognitive impairment, required extensive			

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	assistance of two staff for bathing and personal hygiene. During an observation of care of 06/21/12 at 11:13 a.m., Hospice CNA #1 and CRMA #1 were observed to transfer Resident #1 from the bed to the shower chair. In an interview at that time, Resident #1 indicated he was experiencing pain in his left arm. The Hospice CNA #1 was observed to give Resident #1 a shower in his personal bathroom. In an interview at that time, the Hospice CNA #1 indicated, "I have not observed him to lean in the shower chair." 3.1-3(u)(3)			

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F0246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to ensure a resident who wanted a shower was provided with reasonable accommodations to receive a shower for 1 of 3 residents who met the criteria for Activities of Daily Living. (Resident #1) Findings include: The clinical record of Resident #1 was reviewed on 6/20/12 at 10:44 a.m. The record indicated the diagnoses included, but were not limited to, CVA (Cerebrovascular Accident) (a stroke) with left sided hemiparesis. In a family interview on 06/19/12 at 8:54 a.m., the spouse of Resident #1 stated, "He wants to take a shower and it takes three people to shower him, so he has only had a bedbath for the last two months...They don't have a shower room...for people like	F0246	F 246 Resident #1 has his preferences documented and careplanned accordingly. **Completion Date 7-26-12** Staff that care for Res #1 have been inserviced on his preferences and plan of care. **Completion Date 7-26-12** There were no other residents affected and through inservicing and obtaining preferences will ensure those who want a shower receive it. **Completion Date 7-26-12** Systemic change is that bathing preference will be entered into resident profile on caretracker. **Completion Date 7-26-12** Nursing staff will be inserviced on resident profile procedure and preferences. **Completion Date 7-26-12** DHS/designee will monitor 3 residents bathing preferences per day x2 weeks ,3 per week x2 months and 3 per month	07/26/2012

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	[Resident #1]." Resident #1 was observed on 06/19/12 at 9:00 a.m. to be lying in bed. In an interview, at that time, Resident #1 indicated he would like to take a shower. In an interview with CRCA (Certified Resident Care Associate) Preceptor on 06/20/12 at 10:56 a.m., she indicated Resident #1 was not able to take a shower. In an interview with CRMA (Certified Resident Medication Associate) #1 on 06/21/12 at 11:29 a.m., she indicated Resident #1 received hospice services for bedbaths, but he was not able to take a shower because he leans in the chair. In an interview with MDS (Minimum Data Set Assessment) Coordinator #1 on 06/21/12 at 10:22 a.m., she stated "[Resident #1] does not get a shower related to his inability to stay properly positioned in the shower chair, if he desired a shower [Resident #1] could be brought up to the spa on the second floor. The MDS Coordinator #1 provided, at that time, a Bathing Detail report that indicated Resident #1 had not received a shower or full bath in the last 30 days.		thereafter to ensure care is reflective of resident preference. **Results of audits will be provided to QA committee monthly for review x6 months and quarterly thereafter.**	

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	In an interview with the spouse of Resident #1 on 06/21/12 at 10:45 a.m., she indicated she had no knowledge of a spa on the second floor and that an alternative to a shower had never been offered. The most current care plan for Resident #1 revised on 03/30/12 identified a problem of self-care deficit, "bathing with interventions that included, but were not limited to, ...assist with personal hygiene as needed..." The plan of care did not address any concerns with the resident not being able to take a shower. The most recent Resident First Conference Notes, dated 05/03/12, lacked any documentation of skin concerns, ostomy site concerns, or nursing issues. The meeting summary area lacked any documentation. In an interview with the DoN (Director of Nursing) on 06/22/12 at 10:00 a.m., she indicated the care plan for ADL (Activities of Daily Living) self-care deficit had not been revised to address the new problems and interventions related to Resident #1 wanting a shower.			

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	The most recent quarterly MDS, dated 06/07/12 indicated Resident #1 experienced moderate cognitive impairment, and required extensive assistance of two staff for bathing and personal hygiene. During an observation of care of 06/21/12 at 11:13 a.m., Hospice CNA #1 and CRMA #1 were observed to transfer Resident #1 from the bed to the shower chair. In an interview at that time, Resident #1 indicated he was experiencing pain in his left arm. The Hospice CNA #1 was observed to give Resident #1 a shower in his personal bathroom. In an interview at that time the Hospice CNA #1 indicated, "I have not observed him to lean in the shower chair." 3.1-3(v)(1)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, record review and interview, the facility failed to provide housekeeping services to ensure an odor free room for 1 of 39 residents residing in the facility (Resident #84) and failed to ensure rooms were free of marred walls for 6 of 39 residents residing in the facility. (Resident #5, Resident #163, Resident #168, Resident #173, Resident #174, Resident #176) Findings include: 1. Observation of Resident #84's room and bathroom indicated a strong urine odor for the following dates and times: - 6/19/12 at 10:00 a.m. - 6/19/12 at 2:30 p.m. - 6/20/12 at 9:00 a.m. - 6/20/12 at 1:55 p.m. - 6/21/12 at 7:30 a.m. - 6/21/12 at 2:55 p.m. - 6/22/12 at 7:55 a.m. Observation on 6/22/12 at 7:55 a.m., also indicated newspaper on the resident's floor in his room which was	F0253	F 253 There were no residents affected by this deficiency. Res # 84's room has been cleaned and carpet has been shampooed. **Completion Date 7-26-12** Res #5, #163, #168, #173, #174 and #176 rooms have had repairs including bathrooms and doors. **Completion Date 7-26-12** Housekeeping supervisor will audit 3 rooms/day for 2 weeks, 3 rooms/week for 2 months and 3 rooms/month thereafter. **Completion Date 7-26-12** **Executive Director will receive audit and monitor completion of projects/cleaning schedules for timeliness and report to QA committee on a monthly basis the status of building.** **QA committee will review the building condition report monthly x12 months.**	07/26/2012

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	stuck to the carpet. On interview of Resident #84 on 6/21/12 at 7:50 a.m., Resident #84 indicated the staff assists him with changing his clothes and assisting him to the bathroom. Interview with Hospice CNA (Certified Nurse Aide) #1 on 6/22/12 at 10:22 a.m., indicated the resident "dribbles" urine frequently. Record review on 6/22/12 at 1:15 p.m., indicated the MDS (Minimum Data Survey), dated 3/26/12, indicated Resident #84 was always continent. 2. Resident # 168's room was observed on 6/18/12 at 3:00 p.m. The walls were marred with black marks. 3. Resident # 163's room was observed on 6/19/12 at 8:45 a.m. The walls were marred with black marks. 4. Resident # 173's room was observed on 6/19/12 at 2:25 p.m. The walls were marred with black marks and gouged. 5. Resident # 174's room was			

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	observed on 6/19/12 at 9:48 a.m. The bathroom door had large black marks. 6. Resident # 176's room was observed on 6/19/12 at 10:50 a.m. The walls were marred along a section one foot above the floor. 7. Resident # 5's room was observed on 6/19/12 at 10:03 a.m. The walls were marred throughout with black marks. 3.1-19(f)			

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F0272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, interview, and record review, the facility failed to ensure MDS (Minimum Data Set) assessments were accurate, and reflected the current condition for 1 of 3 residents (Resident #20) reviewed for pressure ulcers in the sample of	F0272	F 272 Res #20 had a modification done to the MDS and was a closed record thus no longer resides in the facility. **Completion Date 7-26-12** Res #163 no longer resides at the	07/26/2012

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	the 3 who met the criteria and for 1 of 3 residents (Resident #163) reviewed for dental status in the sample of 3 who met the criteria. Findings Include: 1. Record review on 6/21/12 at 3:00 p.m., of Resident #20's closed record indicated the resident had entered the facility on 4/12/12. A document titled Skin Impairment Circumstance Investigation, dated 4/30/12, indicated Resident #20 had a left heel pressure area stage 1, with possible deep tissue injury. A document titled "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment," dated 4/30/12, indicated Resident #20 had a left heel pressure ulcer with suspected deep tissue injury and not present on admission had been circled. The pressure area was described as a 3.0 centimeter (cm) in length by 3.0 cm in width, and the depth was unable to be determined. On 5/1/12, the pressure area was described as 3.0 cm in length by 3.0 cm in width, and staged as an E (unstageable). The current treatment was Skin Prep to the heel, Z flow (a device used to lift the heel off the bed), and no shoes. On		facility and through corrective action of dental questionnaire use will ensure any resident with ill fitting dentures will be documented. **Completion Date 7-26-12** Social service and nursing inserviced on dental questionnaire to be done for all new admissions and with each full MDS assessment. **Completion Date 7-26-12** MDS nurses inserviced on coding of pressure ulcers. **Completion Date 7-26-12** Systemic change is that Social Service will keep a log of all residents with dental concerns and coordinate/document follow up accordingly. **Completion Date 7-26-12** DHS/designee will review validation reports of MDS's submitted weekly to ensure those residents with pressure ulcers have been coded and modification done immediately if incorrect. **Results of all audits and dental log will be forwarded to QA committtee monthly x6 months and quarterly thereafter.**	

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	5/8/12, the pressure area to the left heel was described as a 2.2 cm in length by 2.0 cm in width and staged as an E. The treatment was to apply Optifoam (a pressure ulcer treatment) every other day, Z flow, and no shoes. A Minimum Data Set Assessment (MDS), dated 5/1/12, coded the resident as being at risk for developing pressure ulcers but did not have any pressure areas coded at the time. In an interview with the DoN (Director of Nursing) on 06/21/12 at 3:30 p.m., she indicated she did not know how the deep tissue injury could have occurred if the Z flow device had been used. 2. Resident #163 was interviewed on 6/22/12 at 8:35 a.m. She indicated her teeth (dentures) had been loose since she lost weight. She indicated she had been losing weight since her husband died last year. The teeth were observed, during breakfast at that time, to be moving around in the resident's mouth. Resident #163's clinical record was reviewed on 6/21/12 at 4:07 p.m. The admission Minimum Data Set (MDS) assessment, dated 5/21/12, indicated			

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	the resident had no dental problems. 3.1-31(a)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview, and record review, the facility failed to ensure care plans were developed and revised, in that a resident wanted a shower and experienced leakage from his colostomy appliance and the issues were not addressed on the plan of care (Resident #1) for 1 of 2 residents reviewed who met the criteria for colostomy care and 1 of 3 residents reviewed who met the criteria for Activities of Daily Living. Findings include:	F0279	F 279 Resident #1 has careplan updated to reflect shower/bathing interventions and current ostomy appliance. **Completion Date 7-26-12** There were no other residents affected and through inservicing will ensure residents with ostomies have updated careplan and those residents that are unable to take showers have a plan of care reflective of interventions. **Completion Date 7-26-12**	07/26/2012

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	The clinical record of Resident #1 was reviewed on 6/20/12 at 10:44 a.m. The record indicated the diagnoses included, but were not limited to, CVA (Cerebrovascular Accident) (a stroke) with left sided hemiparesis. The most recent quarterly MDS (Minimum Data Set Assessment), dated 06/07/12, indicated Resident #1 experienced moderate cognitive impairment, required extensive assistance of two staff for bathing and personal hygiene. 1. In a family interview on 06/19/12 at 8:54 a.m., the spouse of Resident #1 stated, "He wants to take a shower and it takes three people to shower him, so he has only had a bedbath for the last two months...They don't have a shower room...for people like [Resident #1]." Resident #1 was observed on at that time to be lying in bed on his back. In an interview with CRCA (Certified Resident Care Associate) Preceptor on 06/20/12 at 10:56 a.m., she indicated Resident #1 was not able to take a shower because he leaned in the shower chair. In an interview with CRMA (Certified Resident Care Associate) #1 on		Nursing staff will be inserviced on alternatives to showers and documentation of ADL's as well as ostomy careplanning. **Completion Date 7-26-12** DHS/designee will review ADL report and ostomy careplans 3x/week for 2 months, weekly for 2 months and monthly thereafter. **Completion Date 7-26-12** **Results of audits will be forwarded to QA committee monthly x6 months and quarterly therafter.**	

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	06/21/12 at 11:29 a.m., she indicated Resident #1 received hospice services for bedbaths, but he was not able to take a shower because he leans in the chair. In an interview with MDS Coordinator #2 on 06/21/12 at 10:22 a.m., she stated, "[Resident #1] does not get a shower related to his inability to stay properly positioned in the shower chair, if he desired a shower [Resident #1] could be brought up to the spa on the second floor. The MDS Coordinator #2 provided, at that time, a Bathing Detail report that indicated Resident #1 had not received a shower or full bath in the last 30 days. The most current care plan for Resident #1, revised on 03/30/12, identified a problem of self-care deficit..."needs assistance or is dependent in bed mobility,...personal hygiene, bathing with interventions that included, but was not limited to, assist with personal hygiene as needed..." The plan of care did not address any concerns with the resident not being able to take a shower. In an interview with the DoN (Director of Nursing) on 06/22/12 at 10:00 a.m.,			

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	she indicated the plan of care had not been revised and did not reflect the resident wasn't able to take a shower. 2. Hospice Nurse #2 and LPN #1 were observed on 06/18/12 at 2:52 p.m., providing colostomy care due to leakage to Resident #1. At that time, the skin surrounding the stoma was observed to be bright red, raised, shiny, and excoriated. In an interview at that time, LPN #1 indicated Resident #1 was receiving Diflucan (an oral antifungal medication) for colostomy excoriation. LPN #1 stated, at that time, "...when he goes [has a bowel movement] it just sits on that skin and then it leaks" LPN #1 was then observed to apply a clean colostomy appliance to the excoriated skin surrounding the stoma. A plan of care for skin condition, dated 06/11/12, for "irratiation [sic] at stoma site" with interventions that included, but were not limited to, assess/record changes in skin status, report pertinent changes in skin status to MD, ...protective barrier cream as ordered. The plan of care lacked any documentation related to revising the type of colostomy appliance used. A plan of care for ostomy, dated			

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	03/23/12, included, but was not limited to interventions "observe ostomy site daily for redness/swelling...notify physician of any problems...". The plan of care lacked any documentation related to revising the type of colostomy appliance used. The most recent Resident First Conference Notes, dated 05/03/12, lacked any documentation of skin concerns, ostomy site concerns, or nursing issues. The meeting summary area lacked any documentation. In an interview with the DoN (Director of Nursing) on 06/22/12 at 10:00 a.m., she indicated the plan of care for the ostomy had not been revised to address changing the colostomy appliance. 3.1-35(a)			

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F0282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure services were provided in accordance with the plan of care for 3 of 21 residents reviewed for following the plan of care, in that Resident #1 did not receive personal care and preventive measures for pain, Resident #20 and Resident #88 did not receive pressure prevention measures according to the plan of care. (Resident #1, Resident #20, and Resident #88) Findings include: 1. The clinical record of Resident #1 was reviewed on 6/20/12 at 10:44 a.m. The record indicated the diagnoses included, but were not limited to, CVA (Cerebrovascular Accident) (a stroke) with left sided hemiparesis. A plan of care, dated 03/30/12, for self-care deficit, "needs assistance or is dependent in bed mobility, ...personal hygiene, ...assist with	F0282	F 282 Res #1 has current interventions for pain and personal care being delivered per plan of care and staff that care for him have been inserviced. **Completion Date 7-26-12** Resident #20 and #88 were closed records but through inservicing and monitoring will ensure plan of care for pain and pressure prevention are carried out. **Completion Date 7-26-12** Systemic change is the floating of heels being placed on the TAR for nurses to validate. **Completion Date 7-26-12** Inservice for nursing staff related to pressure prevention and pain management. **Completion Date 7-26-12** DHS/Designee will monitor all TAR's and pain logs 5x/week for 4 weeks, 2x/week for 12 weeks, and weekly thereafter for proper documentation. **Results of monitoring will be forwarded to QA committee**	07/26/2012

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	personal hygiene as needed including oral care, turn and reposition...every hour while in bed/chair...left arm sling when up..." A plan of care, dated 06/18/12, for hospice included, but was not limited to, interventions "observe for signs/symptoms of pain or discomfort, such as facial grimacing, c/o [complaint of] pain, moaning or restless movements and treat per order promptly, notify MD [medical doctor] and hospice if pain or discomfort is not alleviated by current medication treatment regimen..." A plan of care for skin condition, dated 06/11/12, for "irratiation [sic] at stoma site" with interventions that included, but were not limited to, assess/record changes in skin status, report pertinent changes in skin status to MD, ...protective barrier cream as ordered. A plan of care for pain, dated 03/30/12, identified a problem of chronic pain with interventions that included, but were not limited to, repositioning, left arm sling when up, administer...prn (as needed) medications. The plan of care included an additional intervention, dated 06/20/12, for "offer pain meds		**monthly x6 months and quarterly thereafter for review and further recommendations.**	

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	(medications) as needed before and after care..." A plan of care for ostomy, dated 03/23/12, included, but was not limited to interventions "observe ostomy site daily for redness/swelling...notify physician of any problems..." The most recent Resident First Conference Notes, dated 05/03/12, lacked any documentation of skin concerns, ostomy site concerns, or nursing issues. The meeting summary area lacked any documentation. The most recent quarterly MDS (Minimum Data Set Assessment), dated 06/07/12, indicated Resident #1 experienced moderate cognitive impairment, required extensive assistance of two staff for bathing and personal hygiene. The CNA (Certified Nursing Assistant) Assignment sheet, dated 06/13/12, was provided by the Regional Nurse on 06/18/12 at 12:10 p.m. The Assignment Sheet indicated Resident #1 required "splint to right hand at night, required extensive assistance for hygiene and grooming, was to have heels off bed, was a wound risk,			

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	and was to be turned every two hours, required colostomy care every shift, Gerisleeves at all times, splint left arm when up..." Resident #1 was observed on 06/18/12 at 1:00 p.m., to be lying in bed on his back with his buttocks on the mattress. Resident #1 was observed to not have gerisleeves on his arms and his heels were observed to be lying on the mattress. Resident #1 was observed on 06/18/12 at 2:52 p.m., to be lying in bed on his back with his buttocks on the mattress. Resident #1 was observed to not have gerisleeves on his arms and his heels were observed to be lying on the mattress. In an interview, at that time, LPN #1 indicated Resident #1 was to be turned every two hours because he was a high risk for skin breakdown. LPN #1 was then observed to tilt Resident #1's shoulder to the right side and place a pillow behind his upper back. Resident #1 was observed to have his buttocks and heels lying on the mattress. In a family interview on 06/19/12 at 8:54 a.m., the spouse of Resident #1 indicated she had never seen the staff provide oral care to Resident #1.			

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	155723	A. BUILDING 00 B. WING	06/26/2012

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	She further indicated she had provided oral care to Resident #1 on the previous day. Resident #1 was observed on 06/19/12 at 9:00 a.m., lying in bed with his shoulders positioned to the right with a pillow behind his shoulders and his buttocks on the mattress. Resident #1 was observed to not have gerisleeves on his arms, his heels were observed lying on the mattress, and he was observed to have a foul mouth odor. Resident #1 was observed on 06/19/12 at 10:00 a.m., lying in bed with his shoulders positioned to the right with a pillow behind his shoulder and his buttocks on the mattress. Resident #1 was observed to not have gerisleeves on his arms and his heels were observed lying on the mattress. Resident #1 was observed on 06/19/12 at 11:15 a.m., sitting upright in a wheelchair. Resident #1 was observed, at that time, to not have gerisleeves on his arms and was observed to not have a sling on his left arm. Resident #1 was observed on 06/19/12 to have no pressure relief to			

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	his bottom for two hours and 15 minutes. Resident #1 was observed on 06/20/12 at 10:45 a.m., in the main lobby at a music activity with uncombed hair and foul mouth odor. Resident #1 was observed to not have gerisleeves on his arms or a sling to his left arm. Resident #1 was observed on 06/20/12 at 11:53 a.m., sitting in a wheelchair at a dining room table. Resident #1 was observed to not have gerisleeves on his arms or a sling to his left arm. In an interview with CRMA (Certified Resident Medication Associate) #1 on 06/20/12 at 1:30 p.m., she indicated CRCA Preceptor had "just put him [Resident #1] back to bed about 1:15 p.m." Resident #1 was observed, at that time, to be lying in bed on his back with his buttocks and his heels on the mattress. Resident #1 was observed on 06/20/12 at 2:30 p.m., lying in bed with his bottom and heels on the mattress. Resident #1 was observed on 06/20/12 to have no pressure relief to			

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	his bottom for 4 hours and 10 minutes. Resident #1 was observed on 06/21/12 at 9:00 a.m., lying in bed with coccyx and heels lying on mattress. Resident #1 was observed on 06/21/12 at 9:15 a.m., sitting in bed with the head of bed elevated eating breakfast. Resident #1 was observed on 06/21/12 at 11:06 a.m., lying in bed on his back with his bottom and heels lying on the mattress. Resident #1 was observed on 06/21/12 at 11:13 a.m., sitting in a shower chair taking a shower. At that time, a Stage 1 area of pressure was observed on the coccyx. Resident #1 was observed on 06/21/12 at 12:15 p.m., lying in bed on his back with his bottom and heels lying on the mattress. In an interview with MDS (Minimum Data Set Assessment) Coordinator #1 on 06/21/12 at 10:22 a.m., she indicated, oral care should be included with personal hygiene.			

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	2. A closed record review of Resident #20 on 6/21/12 at 3:00 p.m., indicated the resident was admitted to the facility on 4/17/12. A document titled, "Nursing Admission Assessment Data Collection, dated 4/17/12, made no indication of a left heel skin problem, and the skin plan of care was to turn and reposition for comfort with care, prevent skin from touching skin, use lift sheet to reposition in bed, provide pressure relieving device in chair and bed, explain consequences of refusal of treatment and or prevention interventions, and ensure resident is clean and dry. The Nursing Admission Assessment Data Collection document included a hand written note in the margin which was dated 4/30/12 and said, "Z float to float left heel, no shoes, wear non skid socks." A care plan titled skin condition and dated 4/26/12 with a review date of 6/1/12 indicated the resident was at risk for skin areas on lower extremities due to disease process such as : history of cellulitis and wound infection. The interventions included but were not limited to assess skin status and prevent pressure to areas. A care plan titled potential alteration			

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	in skin integrity, dated 4/30/12 and reviewed 6/1/12, indicated interventions including but not limited to Z flow to float left heel, no shoes, wear non skid socks, monitor effectiveness of pressure relieving devices. A treatment record for April documented the Z-flow was being used on 4/30/12 only, and skin prep to the left heel had been done. A treatment sheet for May indicated there was an order, dated 4/30/12, for Z-flow to the heels, but there was no documentation on the treatment sheet that this had been done. The treatment record indicated an order to float heels in bed, dated 5/11/12, and was documented starting 5/12/12. In an interview with the DoN (Director of Nursing) on 6/21/ at 3:45 p.m., she indicated Resident #20's pressure ulcer to the left heel was found on 4/30/12 and was being caused by pressure from Resident #20's shoe. She indicated there was no documentation of floating the heels prior to 4/30/12 and the documentation of using the Z-flow or floating the heels from 5/1/12 until 5/12/12 had not been done. 3. A closed record review of Resident			

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	#88 on 6/22/12 at 11:19 a.m., indicated the resident was admitted to the facility on 1/28/12. A document titled, "Nursing Admission Assessment," dated 1/28/12, indicated Resident #88 had a left hip incision with 26 staples but no indication of any area to the left heel. A document titled, "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment, dated 2/22/12, indicated Resident #88 had a left heel pressure ulcer not present on admission, described as a 3.5 cm in length by 4.5 cm in width and the depth was unable to be determined. The treatment indicated on the assessment was Skin Prep every shift, float heels, no shoes, and gripper socks when out of bed. On 2/28/12, the wound was described as 3.5 cm in width by 5.0 cm in length and a stage of E color black and the treatment was Skin Prep, float heels, low air loss mattress, and no shoes. On 3/6/12, the wound was described as a 2.5 cm in length by 3.5 cm in width a stage E. A care plan titled, Potential for alteration in skin integrity," dated 2/8/12, indicated Resident #88 was at risk due to immobility and diabetes.			

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	The interventions included but were not limited to assess skin for changes, turn and reposition every 2 hours, pressure reducing mattress and heels off bed. The treatment sheets for February and March indicated Resident #88 was to have heels floated in bed, no shoes until healed, wear gripper non skid socks. No documentation of this was noted on the treatment sheets. In an interview with the CRCA (Certified Resident Care Associate) Preceptor on 6/22/12 at 10:30 a.m., she indicated there was not a place on the activities of daily living kiosk computer to document heels being floated. 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for pain management in the sample of 3 who met the criteria for review of pain management. received treatment and services to prevent and treat pain. (Resident #1) Findings include: 1. The clinical record of Resident #1 was reviewed on 6/20/12 at 10:44 a.m. The record indicated the diagnoses included, but were not limited to, CVA (Cerebrovascular Accident) (a stroke) with left sided hemiparesis. The most recent quarterly Minimum Data Set (MDS) assessment, dated 06/07/12, indicated Resident #1 experienced moderate cognitive impairment, required extensive assistance of two for transfers, and	F0309	F 309 Res #1 has current pain assessment and interventions in place and staff that care for him have been inserviced on these. **Completion Date 7-26-12** There were no other residents affected by the alleged deficient practice and through corrective actions will ensure residents with pain will have timely intervention. **Completion Date 7-26-12** Licensed nurses will be inserviced on pain assessment/management. **Completion Date 7-26-12** DHS/Designee will interview 3 random residents/week including resident #1 for pain management x1 month and 3 random residents per month thereafter. **Results of audits will be**	07/26/2012

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	occasionally experienced moderate pain. During an observation of care on 06/18/12 at 2:52 p.m., Hospice Nurse #2 and LPN #1 were providing colostomy care due to leakage to Resident #1. Resident #1 was observed at that time to be grimacing throughout the procedure and stated, "That is so tender!" At that time, the skin surrounding the stoma was observed to be bright red, raised, shiny, and excoriated. LPN #1 stated, at that time, "It's horrible looking, but it did look like hamburger...when he goes [has a bowel movement] it just sits on that skin and then it leaks." LPN #1 was then observed to apply a new colostomy appliance to the excoriated skin surrounding the stoma. During an observation of care on 06/20/12 at 10:20 a.m., Resident #1 was transferred by CRCA (Certified Resident Care Associate) Preceptor and Hospice Nurse #1 from bed to a high back wheelchair via a Hoyer lift. In an interview at that time, Resident #1 complained of pain in his left arm. Resident #1 was observed, at that time, to not have a sling on his left arm.		**forwarded to QA committee for review of compliance and suggestions monthly x6 and quarterly thereafter.**	

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	During an observation of care of 06/21/12 at 11:13 a.m., Hospice CNA #1 and CRMA #1 were transferred Resident #1 from the bed to the shower chair. In an interview, at that time, Resident #1 indicated he was experiencing pain in his left arm. Resident #1 was observed, at that time, to not have a sling on his left arm. A plan of care for pain, dated 03/30/12, identified a problem of chronic pain with interventions that included, but were not limited to, repositioning, left arm sling when up, administer...prn [as needed] medications. The plan of care included an additional intervention dated, 06/20/12, offer pain meds [medicine] as needed before and after care..." A plan of care, dated 06/18/12, for hospice included, but was not limited to, interventions "observe for signs/symptoms of pain or discomfort, such as facial grimacing, c/o [complaint of] pain, ...treat per order promptly, notify MD [medical doctor] and hospice if pain or discomfort is not alleviated by current medication treatment regimen..." The CNA Assignment sheet, dated			

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	06/13/12, was provided by the Regional Nurse on 06/18/12 at 12:10 p.m. The Assignment Sheet indicated Resident #1 required a splint left arm when up..." The most recent June 2012 Physician's Order Recap included orders for Lortab 7.5 mg, give 1 tablet by mouth every 4 hours as needed for mild pain and Lortab 7.5 mg, give two tablets orally every 4 hours as needed for moderate to severe pain. The June 2012 Medication Administration Record indicated no pain medication was administered from June 14, 2012 through June 22, 2012 at 7:30 a.m. In an interview with LPN #1 on 06/22/12 at 9:50 a.m., she indicated the colostomy appliance had been changed daily "for a couple of weeks". The Guidelines for Pain Assessment and Management provided by the HFA (Health Facilities Administrator) on 06/22/12 at 4:00 p.m., indicated, "...1. c. ...or for those cognitively impaired...the assessor shall observe the resident for pathologic conditions that may cause pain and...[facial expressions, body movements...]...5.			

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	Educate the ...care givers on the pain management interventions and importance of notifying staff of changes in pain status." 3.1-37(a)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for ADL's (Activities of Daily Living), in the sample of 3 who met the criteria for review of ADL's received a shower and assistance with dental hygiene. (Resident #1) Findings include: The clinical record of Resident #1 was reviewed on 6/20/12 at 10:44 a.m. The record indicated the diagnoses included, but were not limited to, CVA (Cerebrovascular Accident) (a stroke) with left sided hemiparesis. Resident #1 was observed on 06/19/12 at 9:00 a.m., lying in bed and was observed to have a foul mouth odor. In a family interview on 06/19/12 at 8:54 a.m., the spouse of Resident #1 stated, "... he has only had a bedbath for the last two months..." The spouse of Resident #1 further	F0312	F 312 Res #1 has current interventions for personal care involving showers and dental care being delivered per plan of care and staff that care for him have been inserviced. **Completion Date 7-26-12** Inservice for nursing staff related to shower preferences/refusal or inability to tolerate and dental hygeine. **Completion Date 7-26-12** DHS/Designee will monitor ADL bathing reports and audit 3 random dependent residents for oral care 5x/week for 4 weeks, 2x/week for 12 weeks, and weekly thereafter for proper documentation. **Results of monitoring will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further recommendations.**	07/26/2012

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	indicated she had never seen the staff provide oral care to Resident #1 and she had provided oral care to Resident #1 on the previous day. Resident #1 was observed at that time to appear disheveled and to have foul mouth odor. In an interview with Hospice Nurse #1 on 06/19/12 at 10:18 a.m., she indicated she had bathed and dressed Resident #1. She further indicated at that time that the facility staff would do the oral care after he was gotten up in the chair. In an interview on 6/20/12 at 10:18 a.m., with Hospice Nurse #1 she indicated she had provided no ADL (Activities of Daily Living) assistance to Resident #1. In an interview on 06/20/12 at 10:20 a.m., CRCA Preceptor indicated she had finished providing ADL (Activities of Daily Living) care to Resident #1. CRCA Preceptor was observed to not provide dental care to Resident #1. In an interview with the spouse of Resident #1 on 06/20/12 at 10:36 a.m., she indicated Resident #1 had not received a bath that morning. She further indicated Resident #1 had been dressed while he was in bed by			

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	CRCA (Certified Resident Care Associate) Preceptor and no dental care had been provided. Resident #1 was observed on 06/20/12 at 10:45 a.m., in the main lobby at a music activity with uncombed hair and foul mouth odor. In an interview with CRCA Preceptor on 06/20/12 at 10:56 a.m., she stated, "I gave [Resident #1] a partial bath this morning before breakfast." A Bathing Detail report, provided by MDS Coordinator #2 on 06/21/12 at 10:22 a.m., indicated Resident #1 had not received a shower or full bath in the last 30 days. During an interview, at that time, MDS Coordinator #2 indicated oral care should be included in personal hygiene. In an interview with CRMA (Certified Resident Medication Associate) #1 on 06/21/12 at 11:29 a.m., she indicated, "he can brush his own teeth if we take him into the bathroom while he is sitting in the wheelchair." CRMA #1 further indicated the resident received hospice services for bedbaths. A plan of care, dated 03/30/12, for self-care deficit, "needs assistance or is dependent ...personal hygiene,			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN 47715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	...assist with personal hygiene as needed including oral care,...". The plan of care lacked any specific information related to bathing. The most recent quarterly Minimum Data Set (MDS) assessment, dated 06/07/12, indicated Resident #1 experienced moderate cognitive impairment, required extensive assistance of two staff for bathing and personal hygiene. The CNA Assignment sheet, dated 06/13/12, was provided by the Regional Nurse on 06/18/12 at 12:10 p.m. The Assignment Sheet indicated Resident #1 required extensive assistance for hygiene and grooming, ...should receive a bath on Monday and Thursday." 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C)			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to ensure residents admitted without pressure ulcers did not develop unstageable ulcers for 2 of 4 residents reviewed for pressure ulcers in a sample of 4 who met the criteria for pressure ulcers. Resident # 20's heel wound worsened and required transfer to the hospital. (Resident #20 and Resident #88) Findings include: 1. The closed of Resident #20 was reviewed on 6/21/12 at 3:00 p.m. The resident was admitted to the facility on 04/17/12. The Nursing Admission Data Collection form of 04/17/12 did not indicate a skin condition concern regarding the resident's left heel. A Skin Impairment Circumstance investigation, dated 04/30/12,	F0314	F 314 Resident #20 was a closed record. Resident #88 was a closed record. All residents have the potential to be affected by the alleged deficient practice therefore at risk individuals have been assessed to ensure prevention interventions are in place and careplans updated. **Completion Date 7-26-12** Through inservices and changes in documentation procedure will ensure that interventions are carried out to prevent ulcers from developing or worsening.. **Completion Date 7-26-12** Systemic change will include signing on TAR to reflect heels floating. **Completion Date 7-26-12** Nursing staff will be inserviced on	07/26/2012

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	documented a left heel pressure area, Stage 1 with possible deep tissue injury. The Pressure/Stasis/Arterial/Diabetic Ulcer form indicated the area was not present on admission and measured 3.0 X 3.0 and the depth was unable to be determined. A physician's order was obtained on 04/30/12 for Skin Prep to the left heel every shift and as needed along with a Z-flow (a device to provide complete pressure relief) when in bed to float the heels. The left heel was measured again on 05/01/12 and the measurements recorded on the Pressure Ulcer form were the same as 04/30/12. A Nurses note, dated, 05/05/12, indicated the resident had an area to the left heel with red bed and slough and a new order for Optifoam (a specialty dressing) every three days and as needed. A Physician's order, dated 05/05/12, indicated Resident #20 was to have the left heel cleansed with wound cleanser and apply Optifoam every three days and as needed. On 05/08/12, the Pressure Ulcer Assessment indicated the heel wound measurement was 2.2 cm		new documentation procedure as well as repositioning requirements and pressure relief. **Completion Date 7-26-12** DHS/designee will audit TAR's daily for heel floating documentation. DHS/Designee will conduct daily rounds to ensure that pressure reduction interventions are being carried out for a random sample of 3 residents/day x4 weeks, then 3 residents/week thereafter. **Results of audit as well as full skin report will be forwarded to the QA committee monthly x12 months and suggestions/recommendations carried out as deemed necessary by committee**.	

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	(centimeters) X 2.0 cm and unstageable. A Physician's order, dated 05/08/12, indicated an order to revise the Optifoam order to be done every other day and as needed. A nurses note, dated 5/11/12 at 12:00 p.m., indicated the left lower extremity dressing was removed and there was severe discoloration with multiple new bruises and wounds. A nurses note, dated 5/11/12, with no time indicated Resident #20 had an acute change to the left foot and a new order was received to send Resident #20 to the emergency room. A doctors order, dated 5/11/12, indicated Resident #20 was to be sent to the emergency room. A Minimum Data Set Assessment (MDS), dated 5/1/12, coded the resident as being at risk for developing pressure ulcers but did not have any pressure areas coded at the time. A care plan for skin condition, updated 6/1/12, identified the resident as at risk for skin areas on lower extremities due to disease process			

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	such as: history of cellulitis and wound infection. The interventions included but were not limited to assess skin status and prevent pressure to areas. A care plan titled potential alteration in skin integrity, dated 4/30/12 and reviewed 6/1/12, indicated interventions including but not limited to Z flow to float left heel, no shoes, wear non skid socks, monitor effectiveness of pressure relieving devices. A treatment record for April documented the Z-flow was being used on 4/30/12 only, and skin prep to the left heel had been done. A treatment sheet for May indicated there was an order, dated 4/30/12, for Z-flow to the heels, but there was no documentation on the treatment sheet that this had been done. The treatment record indicated an order to float heels in bed, dated 5/11/12, and was documented starting 5/12/12. In an interview with the DoN (Director of Nursing) on 6/21/12 at 3:45 p.m., she indicated Resident #20's pressure ulcer to the left heel was found on 4/30/12 and was being caused by pressure from Resident #20's shoe. She indicated there was			

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	no documentation of floating the heels prior to 4/30/12 and the documentation of using the Z-flow or floating the heels from 5/1/12 until 5/12/12 had not been done. 2. The closed record of Resident #88 was reviewed on 6/22/12 at 11:19 a.m. The resident was admitted to the facility on 1/28/12. The Nursing Admission Assessment Data Collection form of 1/28/12 did not indicate a skin condition concern regarding the resident's left heel. The February 2012 treatment sheet indicated weekly skin assessments were performed for Resident #88 on 02/07/12, 02/14/12, and 02/21/12. Each of these assessments indicated an existing area of impairment. A care plan titled potential for alteration in skin integrity, dated 2/8/12, indicated Resident #88 was at risk due to immobility and diabetes. The interventions included but were not limited to assess skin for changes, turn and reposition every 2 hours, pressure reducing mattress and heels off bed. The Pressure/Stasis/Arterial/Diabetic Ulcer form, dated 02/22/12, indicated the area was not present on			

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	admission and measured 3.5 cm X 4.5 cm and the depth was unable to be determined. The form indicated the treatment was Skin Prep every shift, float heels, no shoes, and gripper socks when out of bed. The form indicated on 2/28/12, the wound was black in color, staged as "E" (unstageable)measured 3.5 cm X 5.0 cm and the treatment was Skin Prep, float heels, low air loss mattress, and no shoes. The form indicated on 3/6/12, the wound was unstageable and measured 2.5 cm X 3.5 cm. A doctor's order, dated 2/22/12, indicated Resident #88 was to have Skin Prep to left heel every shift and as needed, no shoes, wear gripper non skid socks in bed and float heels in bed. The treatment sheets for February and March indicated Resident #88 was to have heels floated in bed, no shoes until healed, wear gripper non skid socks. The February 2012 and March 2012 treatment sheets lacked any documentation of heels being floated, no shoes, or gripper nonskid socks. In an interview with the CRCA (Certified Resident Care Associate) preceptor on 6/22/12 at 10:30 a.m.,			

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	she indicated there was not a place on the activities of daily living kiosk computer to document heels being floated. The Pressure Prevention Guideline was provided by the HFA (Health Facilities Administrator) on 6/26/12 at 12:00 p.m., and indicated the facility would "elevate heels off the bed-avoid use of 'heel protectors' and protect elbows and float heels as needed... Purpose... provide measures that will promote and maintain good skin integrity" on residents with potential and or actual impairment or skin integrity. 3.1-40(a)(1) 3.1-40(a)(2)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure chemicals were kept locked and out of reach of residents for 1 of 3 units observed. A housekeeping closet was left unlocked, open, and unattended with chemicals inside. (Transitional Care Unit 600) Findings include: On 6/21/12 at 3:00 p.m., a housekeeping closet was observed unlocked, opened wide, and unattended on the Transitional Care Unit 600. The following items were observed in the closet: -Oxivir 5:16 concentrate disinfectant cleaner. The label included, but was not limited to, the following instructions: Keep out of reach of children. Harmful if swallowed. -Jet Stream Extraction Carpet Cleaner. The label included, but was not limited to, the following instructions: Caution keep out of reach of children. Mild eye irritant	F0323	F 323 There were no residents affected by the alleged deficient practice and through corrective actions will ensure hazardous chemicals are locked up. **Completion Date 7-26-12** All departments will be inserviced on proper care and storage of chemicals. **Completion Date 7-26-12** Housekeeping supervisor/designee will randomly audit all closets daily to ensure items are secured. **Results of monitoring will be forwarded to QA committee monthly x6 months and quarterly thereafter.**	07/26/2012

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	and slight skin irritant. First aide, flush eyes, flush skin, ingestion two large glasses of water. Do NOT induce vomiting. Call physician. The Administrator provided a document entitled "Daily Cleaning Procedures Resident Rooms," on 6/26/12 at 11:55 a.m. Documentation included, but was not limited to, the following: "Pull your stocked cart in front of the room that you are cleaning. Make sure that you do not leave chemicals on the top of the cart and that your cart is locked." In interview at this time, she indicated it was the only documentation she could find of requiring chemicals to be locked up. 3.1-45(a)(1)			

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F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record review, the facility failed to ensure 1 of 2 residents reviewed for colostomy, in the sample of 2 who met the criteria for review of colostomy, received prompt care and change in treatment. Resident #1 experienced leakage from a colostomy appliance being applied on excoriated skin that resulted in Resident #1 experiencing pain when the appliance was changed and continued irritation to the skin from the ill-fitting colostomy appliance. Findings include: Hospice Nurse #2 and LPN #1 were observed on 06/18/12 at 2:52 p.m., providing colostomy care due to leakage to Resident #1. Resident #1 was observed at that time to be grimacing throughout the procedure	F0328	F 328 Resident #1 has careplan updated to reflect current ostomy care and appliance. **Completion Date 7-26-12** There were no other residents affected and through inservicing will ensure residents with ostomies have proper care and treatment of it. **Completion Date 7-26-12** Licensed nurses will be inserviced on ostomy care and treatment. **Completion Date 7-26-12** DHS/designee will audit residents with ostomies: careplans, peristoma condition and appliance/tx 3x/week for 2 months, weekly for 2 months and monthly thereafter. **Results of audits will be forwarded to QA committee monthly x6 months and**	07/26/2012

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	and stated, "That is so tender!" At that time, the skin surrounding the stoma was observed to be bright red, raised, shiny, and excoriated. In an interview at that time, LPN #1 indicated Resident #1 was receiving Diflucan (an oral antifungal medication) for colostomy excoriation. LPN #1 stated, at that time, "It's horrible looking, but it did look like hamburger...when he goes [has a bowel movement] it just sits on that skin and then it leaks" The Hospice nurse stated, at that time, "we are gonna come out Thursday (6/21/12) and assess for new appliance." LPN #1 was then observed to cleanse the skin around the stoma with moistened gauze and apply a new colostomy appliance to the excoriated skin surround the stoma. LPN #1 was not observed to apply any cream or protective barrier to the peri stoma area before applying the colostomy wafer to the excoriated skin. The clinical record of Resident #1 was reviewed on 6/20/12 at 10:44 a.m. The record indicated the diagnoses included, but were not limited to, CVA (Cerebrovascular Accident) (a stroke) with left sided hemiparesis.		**quarterly therafter.**	

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	The most recent quarterly MDS (Minimum Data Set Assessment), dated 06/07/12, indicated Resident #1 had an ostomy. The June 2012 Physician's Order Recap included, but was not limited to, the following orders: 10/06/11 Nizoral 2% cream apply to stoma every day until healed. 03/30/11 Colostomy care every shift 03/30/11 Change ostomy bag and wafer every three days and as needed peri stoma area cleanse. A Physician's Progress Note, dated 06/07/12, indicated, "site at ostomy [arrow up] red...substancial [sic] redness around his ostomy...ostomy site candidiasis..." The Nursing Notes from 06/07/12 at 7:45 p.m. through 06/21/12 at 1:00 p.m., were reviewed and lacked any documentation that the attending physician had been notified the colostomy appliance was not functioning due to the excoriated skin. A plan of care, dated 06/18/12, for hospice included, but was not limited to, interventions "observe for signs/symptoms of pain or discomfort, such as facial grimacing, c/o [complaint of] pain, moaning or			

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	restless movements and treat per order promptly, notify MD [medical doctor] and hospice if pain or discomfort is not alleviated by current medication treatment regimen..." A plan of care for skin condition, dated 06/11/12, for "irratiation [sic] at stoma site" with interventions that included, but were not limited to, assess/record changes in skin status, report pertinent changes in skin status to MD, ...protective barrier cream as ordered. A plan of care for pain, dated 03/30/12 identified a problem of chronic pain with interventions that included, but were not limited to, repositioning, left arm sling when up, administer...prn [as needed] medications. The plan of care included an additional intervention dated, 06/20/12, offer pain meds [medicine] as needed before and after care..." A plan of care for ostomy, dated 03/23/12, included, but was not limited to interventions "observe ostomy site daily for redness/swelling...notify physician of any problems..." In an interview on 6/20/12 at 10:18			

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	a.m,. with Hospice Nurse #1 she indicated the new colostomy supplies "will be taken care of by the hospice wound care person on 06/21/12." In an interview with LPN #1 on 06/22/12 at 9:50 a.m., she indicated the colostomy appliance had been changed daily "for a couple of weeks" and there had been no change to the type of colostomy appliance used for Resident #1. In an interview with the DoN (Director of Nursing) on 06/22/12 at 10:00 a.m., she indicated the plan of care for the ostomy had not been revised to address the periwound rash, alternate treatment, or the colostomy appliance. The DoN further indicated at that time, the physician had not been notified of the rash around the stoma interfering with the functioning of the colostomy appliance. 3.1-47(a)(3)			

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F0332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free of medication error rates of five percent or greater, for 3 of 13 residents observed during medication administration, in that 4 errors were made out of 58 opportunities for error, resulting in an error rate of 6.89 percent. Three (3) of 4 licensed nurses observed made errors. (Residents #101, #8, #179) (RN #1 , RN #2, and LPN #1) Findings include: 1. On 6/21/12 at 8:14 a.m., RN #1 was observed preparing to administer medications via gastrostomy tube to Resident #101. The RN indicated she had a question about the resident's order. The Medication Administration Record (MAR) was observed to indicate the medication as "Calcium with Vitamin D 600/400 liquid daily per peg tube." The bottle of liquid was observed and indicated a concentration of 1250 milligrams (mg) per 5 milliliters (ml). The label indicated they were to give 6 ml for	F0332	F 332 Resident #8 has orders clarified to administer sliding scale as ordered and eliminate the "don't give more than 8 units with sliding scale". **Completion Date 7-26-12** Resident #101 received meds as ordered **Completion Date 7-26-12** Resident #179 received meds as ordered and suffered no ill effects from not receiving it with food. **Completion Date 7-26-12** RN#1 and RN#2 as well as LPN #1 have completed medication administration course and have had a med pass observation completed. All other staff that pass meds will be inserviced. **Completion Date 7-26-12** All residents receiving medication have the potential to be affected by the alleged deficient practice and through inservicing and observations will ensure medications are given as ordered. **Completion Date 7-26-12** DHS/designee will: perform medication pass audit monthly for	07/26/2012

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	155723	A. BUILDING 00 B. WING	06/26/2012

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	600 mg of elemental calcium. There was no indication of Vitamin D being in the liquid. The nurse called the pharmacy for clarification. She indicated the pharmacist indicated she should follow the instructions on the liquid calcium bottle, to give 6 ml of the liquid. She further indicated the vitamin D was a separate solution and they were to give two drops to equal the 400 international units ordered. RN #1 was then observed to pour an amount of the calcium liquid into a 30 ml measuring cup. The cup was observed to be marked for 2.5 ml, 5 ml, 7.5 ml, 10 ml, 15 ml, 20 ml, 25 ml, and 30 ml. The liquid level was somewhere between the 5 ml and 7.5 ml mark. She indicated she was giving 6 ml. As she prepared to move on to the next medication, she summoned another staff person and asked that person to go get her a 10 ml syringe. RN #1 was then observed to draw up the calcium liquid into the syringe. She stated, "Let's see how close I was?" She then indicated the syringe held 6 ml. The syringe was observed and it held 5.6 ml of the calcium liquid; the plunger was not equal to the 6 ml line. The nurse was		6 months and then quarterly, review prescribed orders for accuracy daily for 2 weeks then one time weekly for one month then continue with pharmacist audits every 60 days. **Results of audits will be forwarded to QA committee monthly x6 months and then quarterly for review and further suggestion**.	

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	requested to check the amount again. At that time, she added some calcium liquid to equal the 6 ml. She did include the 2 drops of Vitamin D liquid when she administered the medications. Resident #101's clinical record was reviewed on 6/21/12 at 11:57 a.m. The physician's orders included an order, dated 5/25/12, for Calcium with vitamin D 600/400 liquid daily per peg tube. There was no clarification of the order. The medication label, reviewed again at that time, indicated the facility was to administer 6 ml of the Calcium. 2. On 6/21/12 at 11:14 a.m., LPN #1 was observed to check the blood sugar of Resident #8. The blood sugar monitor indicated the resident's blood sugar was 242. LPN #1 indicated, at that time, the resident routinely received Humalog 4 units with the lunch meal. She indicated the resident was to receive 6 units for a blood sugar of 242. She was then observed to draw up 10 units of Humalog insulin and administer it subcutaneously into Resident #8's abdomen. Resident #8's clinical record was			

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	reviewed on 6/22/12 at 11:00 a.m. The record indicated the physician's orders, signed 6/18/12, indicated "Humalog 100 Units/ML vial inject 4 units sub-Q with each meal **Do not give more than 8 units with SS [sliding scale]." Humalog SS: "201-250= 4 units..." LPN #1 was interviewed, at that time, and indicated she had given 10 units; it was a mistake. 3. On 6/22/12 at 7:47 a.m., RN #2 was observed to administer medications to Resident #179. The medications included, but were not limited to, the following: Aspirin 325 mg (milligrams) one tablet by mouth K-tabs (potassium supplement) 20 milliequivalents (meq) one tablet by mouth. No food was given with the medications. The resident had not had breakfast at that time. Resident #179's clinical record was reviewed on 6/22/12 at 8:23 a.m. The physician's orders, signed 6/19/12, indicated the orders for the medications were as follows: ASA (aspirin) 325 mg i po (by mouth) q (every) am (morning) with breakfast K-tabs 20 meq i po bid (twice a day) take with meal or snack			

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	The resident was observed to receive his breakfast tray on 6/22/12 at 8:30 a.m. 4. The Medication Administration Times Procedural Guidelines, dated November, 2011, was provided by the Consultant Nurse on 6/18/12 at 12:10 p.m. The policy and procedure included, but was not limited to, the following: "Medications that have been ordered at specific time shall be administered at the time designated by the attending physician." "Medications that are to be received prior to, with or after meals shall be administered at these times yet in accordance with the resident's self-determined schedule..." 3.1-25(b)(9) 3.1-48(c)(1)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure frozen foods were stored in the freezer below zero degrees and bins containing dry foods were not exposed to potential contamination in 1 of 1 kitchens potentially affecting 39 residents who ate at the facility. Findings include: #1. During the initial kitchen tour on 6/18/12 at 10:30 a.m., an observation was made of an exterior freezer thermometer registering 20 degrees on the freezer by the entrance door of the kitchen. The interior thermometer did not register a temperature due to the temperature indicator line being broken and loose in the thermometer. In an interview during the initial tour, the Food Services Assistant indicated the exterior thermometer was broken and so was the interior thermometer. She indicated there was not a log of daily temperatures for this freezer.	F0371	F 371 The freezer is in current working order and with working thermometer. All freezers and fridges have a temperature log in place. All opened containers are dated and dry bulk storage lids are in place. **Completion Date 7-26-12** There were no residents affected by the alleged deficient practice and through corrective actions will ensure storage of frozen foods and dry food storage containers have lids secured. **Completion Date 7-26-12** Dietary employees have been inserviced on food storage, sanitation, food handling and safe temperature food code regulations. **Completion Date 7-26-12** Director of food service/designee will monitor and/or verify freezer temps at or below 0 degrees daily and conduct sanitation/food storage audits daily. **Results of audits will be**	07/26/2012

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	On 6/18/12 at 11:43 a.m., an observation was made of the new interior freezer thermometer by the entrance door of the kitchen registering 25 degrees. On 6/18/12 at 3:28 p.m., an observation was made of the interior freezer thermometer of the freezer by the entrance door of the kitchen registering 10 degrees. Record Review on 6/18/12 at 10:30 a.m., of the refrigerator/freezer temperature log indicated there was no record of past temperatures for the freezer by the entrance to the kitchen. On 6/19/12 at 8:30 a.m., an observation was made of the interior freezer thermometer in the freezer by the entrance to the kitchen registering 0 degrees. The exterior thermometer registered 10 degrees. In an interview with the Administrator on 6/19/12 at 8:30 a.m., she indicated the problem was not a freezer temperature problem. The exterior thermometer was broken and the interior thermometer temperature was registering 10 degrees because the kitchen employees had been opening it to retrieve food.		**forwarded to QA committee monthly for 6 months and quarterly thereafter for review and further recommendations**.	

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On 6/20/12 at 8:30 a.m., an observation was made of the exterior freezer thermometer on the freezer by the kitchen entrance registering 38 degrees. The interior thermometer registered 28 degrees. There was no food in the freezer at this time. The Food Service Assistant indicated the freezer had heated up overnight and was not working at that time.

#2. An observation during the initial tour on 6/18/12 10:35 a.m., was made of an opened cottage cheese container half full with no date to indicate the day the cottage cheese was opened. In an interview at this time with the Food Services Assistant she indicated someone had forgotten to date the cottage cheese.

#3. During initial kitchen tour on 6/18/12 at 10:37 a.m., a bin of flour was observed to be open with the lid propped across the bin, but not covering the bin of flour. A box with a bag of bulk sugar was open to air.

An observation was made on 6/21/12 at 11:30 a.m., of a box with a bag of bulk sugar in it. The bag was wide open to air.

A document provided by the

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	Administer on 6/26/12 at 9:45 a.m., and titled Storage Procedures, dated 2009, indicated dry bulk food was to be stored in plastic containers with tight covers or bins which are easily sanitized. The document indicated open packages would be dated and stored in closed containers and frozen storage temperatures would be zero degrees Fahrenheit or below. Thermometers would be placed in every freezer and temperatures would be recorded on the freezer log at least twice a day. 3.1-21(i)(2) 2-5-5.1(f)			

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F0411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview, and record review, the facility failed to ensure prompt referral to a dentist for a resident with loose and ill- fitting partial dentures. This affected 1 of 3 residents reviewed in a sample of 3 who met the criteria for dental care. (Resident #15) Findings include: Record review on 6/20/12 at 2:45 p.m., indicated Resident #15 had a care plan for dental care dated 6/12/12. The care plan indicated the resident had a loose partial. The interventions included oral care concerns were to be discussed with the resident or responsible party. An ADL (Activities of Daily Living) care	F0411	F 411 Resident #15 suffered no ill effects from the alleged deficient practice and doesn't wish to have dental consult completed. **Completion Date 7-26-12** There were no other residents affected by the alleged deficient practice and through use of dental questionnaire will ensure there is follow up of consults. **Completion Date 7-26-12** Systemic change is the addition of dental questionnaire completed for all new admissions by Social Service Director for follow up. **Completion Date 7-26-12** Social Service Director/designee will update the dental log as	07/26/2012

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	plan, dated 6/12/12, indicated the resident would be assisted with oral/denture care. Interview with Resident #15 on 6/19/12 at 11:34 a.m., indicated Resident #15 had missing teeth and dental issues related to his loose fitting upper partial and his lower dentures. The resident indicated his top partial is unable to be anchored to his permanent teeth and when he wore the upper partial the wires would hurt his mouth. Observation on 6/21/12 at 8:30 a.m., indicated the staff offered to brush Resident #15's teeth. The resident refused to have his upper partial plate brushed and placed in his mouth. The resident indicated the wires that anchored the partial plate to his permanent teeth hurt his teeth whenever the wires touched them and he had not been wearing it. The resident allowed his bottom denture to be brushed but had difficulty putting the bottom denture into his mouth. U.M. (Unit Manager) #1 had attempted to also put the resident's teeth into his mouth but was unable to do so. Resident #15 indicated the bottom denture was too big to go into his mouth.		referenced in F272 POC daily to ensure that medical record contains sufficient information and description of follow up required. **Log Results of Social Service monitoring that includes residents with dental issues will be forwarded to QA committee monthly for review and further suggestions x 6 months and quarterly thereafter.**	

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	On interview with LPN #1 on 6/21/12 at 8:45 a.m., she indicated she did not know the resident's teeth were bad and that no one had reported it to her. On interview with SSD (Social Services Designee) #1 on 6/22/12 at 8:15 a.m., she indicated she was unaware the resident had any dental issues. She indicated she was unaware the resident had a care plan for dental care regarding his loose plate. SSD #1 indicated no one had reported to her regarding the resident's dentures or partial plate. The policy for oral care guidelines, obtained from the ED (Executive Director) on 6/22/12 at 4:00 p.m. and dated 6/10, indicated in providing care to dentures, any changes noted to dentures were to be reported to the nurse. 3.1-24(a)(3)			

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to provide routine drugs and biologicals to 1 of 13 residents observed during the medication passes, in that an order for Calcium with Vitamin D was not clarified, was provided in separate liquid solutions, and the staff admittedly were not always giving the Vitamin D. (Resident #101) Finding includes: On 6/21/12 at 8:14 a.m., RN #1 was	F0425	F 425 Resident #101 had order clarified. **Completion Date 7-26-12** RN#1 has completed medication administration course and has had a med pass observation completed. All other staff that pass meds will be inserviced. **Completion Date 7-26-12** There were no other residents with this order but through corrective action will ensure that the order is clearly labeled and separate by pharmacy if the 2 meds are not in 1 solution. **Completion Date 7-26-12**	07/26/2012

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	observed preparing to administer medications via gastrostomy tube to Resident #101. The RN indicated she had a question about the resident's order. The Medication Administration Record [MAR] was observed to indicate the medication as "Calcium with Vitamin D 600/400 liquid daily per peg tube." The bottle of liquid was observed and indicated a concentration of 1250 milligrams [mg] per 5 milliliters [ml]. The label indicated they were to give 6 ml for 600 mg of elemental calcium. There was no indication of Vitamin D being in the liquid. The nurse called the pharmacy for clarification. She indicated the pharmacist indicated she should follow the instructions on the liquid calcium bottle, to give 6 ml of the liquid. She further indicated the vitamin D was a separate solution and they were to give two drops to equal the 400 international units ordered. The generic vitamin D solution, ergocalciferol, was observed. It appeared to be full. It was filled on 5/29/12. The Medication Administration Record indicated the Calcium with Vitamin D 600/400 had been given daily 6/1 through 6/20/12. RN #1 indicated, at that time, she had given the calcium previously in June,		DHS/designee will: perform medication pass audit monthly for 6 months and then quarterly, review prescribed orders for accuracy daily for 2 weeks then one time weekly for one month then continue with pharmacist audits every 60 days. **Results of audits will be forwarded to QA committee monthly x6 months and then quarterly for review and further suggestion**.	

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	2012, some of the initials on previous days were hers, but she had not included the vitamin D at that time; she had not known it was a separate solution. RN #1 was then observed to pour an amount of the calcium liquid into a 30 ml measuring cup. The cup was observed to be marked for 2.5 ml, 5 ml, 7.5 ml, 10 ml, 15 ml, 20 ml, 25 ml, and 30 ml. The liquid level was somewhere between the 5 ml and 7.5 ml mark. She indicated she was giving 6 ml. As she prepared to move on to the next medication, she summoned another staff person and asked that person to go get her a 10 ml syringe. RN #1 was then observed to draw up the calcium liquid into the syringe. She stated, "Let's see how close I was?" She then indicated the syringe held 6 ml. The syringe was observed and it held 5.6 ml of the calcium liquid; the plunger was not equal to the 6 ml line. The nurse was requested to check the amount again. At that time, she added some calcium liquid to equal the 6 ml. She did include the 2 drops of Vitamin D liquid when she administered the medications.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #101's clinical record was reviewed on 6/21/12 at 11:57 a.m. The physician's orders included an order, dated 5/25/12, for Calcium with vitamin D 600/400 liquid daily per peg tube. There was no clarification of the order. The medication label, reviewed again at that time, indicated the facility was to administer 6 ml of the Calcium. 3.1-25(e)(1) 3.1-25(o)			

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	155723	A. BUILDING 00 B. WING	06/26/2012

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to	F0441	F 441	07/26/2012

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	ensure infection control procedures were followed for 3 of 7 residents observed for personal care, in that handwashing and glove use were not performed as required. (Resident #15, Resident #87, Resident #78) Findings include: 1. During an observation on 6/21/12 at 8:30 a.m., LPN #1 and Unit Manager (UM) #1 assisted Resident #15 to the bathroom. LPN #1 and UM #1 applied their gloves without washing their hands before placing the resident on the commode. UM #1 removed the resident's brief and applied clean clothing to the resident without changing her gloves or washing her hands. 2. CRMA (Certified Resident Medication Associate) #1 was observed to assist Resident #87 to the bathroom using a Sara lift (a mechanical device with a sling used for position changes) on 06/21/12 at 11:00 a.m. In an interview on 06/21/12 at 11:05 a.m., CRMA #1 indicated Resident #87 had urinated. At that time, CRMA #1 was observed to provide peri care to Resident #87. CRMA #1 was observed, at that time, to not remove the soiled gloves before applying the resident's		Res #15 suffered no ill effects from the findings on the 2567L and staff have been inserviced on glove usage/changing and handwashing. **Completion Date 7-26-12** Res #87 and #78 suffered no ill effects and through corrective actions will ensure that glove usage/changing and handwashing occur per policy to prevent spread of infection.. **Completion Date 7-26-12** All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and inservicing will ensure corrective actions to prevent spread of infection are followed. **Completion Date 7-26-12** Nursing staff will be inserviced on proper handwashing and glove usage procedures to prevent spreading of infection. **Completion Date 7-26-12** DHS/Designee will monitor resident care that includes handwashing/glove usage after care and techniques of all care provided daily x5days, 3xweek for 2 weeks, then weekly. **Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further**	

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	incontinence brief and clothing. The guidelines for handwashing, provided by the HFA (Health Facilities Administrator) 6/22/12 at 4:00 p.m. and dated 10/04, indicated all health care workers should wash their hands frequently and appropriately. Health care workers are to wash their hands after removing gloves, after having direct contact with residents, having direct contact with excretions, and having direct contact with resident equipment. The guidelines lacked any information regarding changing gloves between clean and dirty procedures. 3. An observation was made on 6/21/12 at 09:30 a.m., of CRCA (Certified Resident Care Associate) #3, CRMA (Certified Care Medication Associate) #1, and UM (unit manager) #1 giving incontinence care to Resident #78. CRCA #3, CRMA #1, and UM #1 entered the room and applied gloves without washing hands. They then assisted the resident into bed with a mechanical lift. CRCA #3, CRMA #1, and UM #1 rolled Resident #78 to the left and CRMA #1 wiped Resident #78 with incontinent wipes and removed the dirty brief. CRMA #1 changed gloves		**suggestions/comments**.	

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	without washing hands put a new brief on Resident #78 and put rolled up dirty brief in trash bag. CRMA #1 removed gloves and carried bag to closet out in hallway touching the door handle. CRCA #3 put Resident #78's bedside table in place then removed gloves and continued out the door along side of CRCA #3. After depositing the dirty bag into the closet, both went to the nurses' station and then washed hands. 3.1-18(l)			

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R0244	410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on observation and interview, the facility failed to ensure medications were not set up for multiple residents without proper identification during medication administration observed on 1 of 2 assisted living units. (Unit 200) Finding includes: On 6/21/12 at 3:30 p.m., a medication cart was observed unlocked and unattended outside a resident room on Unit 200. The drawer was easily opened. No one was in sight of the cart. Inside the top drawer, there were 15 paper souffle type medication cups with assorted medication tablets and capsules. LPN #2 exited the resident room and asked if she could be of help. During interview, at that time, LPN #2 indicated the medications in the top drawer were for her medication pass. She indicated she knew who each paper cup of medications was for because she marked it on the bottom of the cup. Upon request, she lifted out four separate medications cups. There were no identifying markings	R0244	R 244 LPN #2 was terminated from employment. All residents have the potential to be affected by the alleged deficient practice and through medication inservicing will ensure that meds are not set up for more than 1 scheduled administration and without identifying markings. **Completion Date 7-26-12** Licensed personnel will be inserviced on medication administration and complete post test for understanding. **Completion Date 7-26-12** AL manager/designee will perform medication administration observation audits 3x/week for 1 month and then 3x/month randomly on all shifts with all AL nurses. **Results of audits will be forwarded to QA for review monthly x 12 months.**	07/26/2012

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	anywhere on the cups. She stated, "I just know who gets what." At that time, she began picking up all the cups with medications in them and indicated she would throw them away and start over. The Administrator was immediately informed of the observation. She indicated, at that time, the nurse should not be setting up multiple resident medications in advance of the medication pass without identification of each resident's medications.			

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R0304	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview and record review, the facility failed to ensure medication carts were locked when out of view of the nursing staff, for 1 of 2 assisted living units (Unit 200). Finding includes: On 6/21/12 at 3:30 p.m., a medication cart was observed outside a room on the 200 unit. The medication cart was unlocked; the drawers easily opened. The door to the resident room was slightly opened. No one was in sight of the cart. The top drawer was observed to contain 15 paper souffle cups with assorted medication tablets in them. The other drawers contained bubble pack type packaged medications belonging to residents. LPN #2 exited the resident room. She indicated she had left the cart unlocked. She indicated the pills in	R0304	R 304 All residents have the potential to be affected by the deficient practice and through corrective measures and in-servicing staff we will ensure that med carts are locked when out of view. **Completion Date 7-26-2012** Licensed nursing personnel will be in-serviced on the proper med cart security procedures. **Completion Date 7-26-2012** AL manager/designee will audit med carts for proper security/storage randomly on all shifts 3x/week for 2months and then 3x/monthly. **Results of the audits will be forwarded to the QA committee monthly for 6 months and quarterly thereafter.**	07/26/2012

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	the souffle cups were for her medication pass. The Administrator provided the policy and procedure for medication storage in the facility, dated 2/1/10, on 6/26/12 at 11:55 a.m. The policy included, but was not limited to, the following: "Medications and biologicals are stored safely, securely, and properly... The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." "...Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access."			